Some Problems of the Physicians on the Navajo Reservation

*John Adair and Kurt Deuschle, M.D.**

Since World War II there has been a great increase in the number of United States medical personnel working in the so-called "underdeveloped" areas of the world. This expansion in the delivery of scientific medicine is caused by a number of factors. Prominent among these are the great increase in military bases in foreign countries, where the doctors and nurses frequently treat native civilian personnel as well as U.S. troops, and to United States participation in international health programs such as the Pan-American Sanitary Bureau, International Cooperation Administration and other technical assistance programs.

In addition to these organizations, in 1955 the United States Public Health Service became responsible by Congressional Act for rendering a health service on all U.S. Indian Reservations with a few exceptions, and to the Indians, Aleuts, and Eskimos residing in Alaska. This had formerly been the responsibility of the Bureau of Indian Affairs of the Department of the Interior. Today many young doctors are now recruited through the Universal Military Training and Service Act, for service in the Indian Health Program.

In a recent survey[1] reported to the Surgeon General, Public Health Service, the problem with young physicians in the Indian Health Program was emphasized:

"The youth and short length of service of many of the physicians in the Indian Health Program make for difficulties in program and administration. Over 40 per cent of the medical officers in charge of Indian hospitals are under 30 years of age, and about half are in the Public Health Service, serving their two years under the Doctor-Dentist Draft. These physicians, most of whom are trained and interested primarily in clinical medicine, are expected to assume responsibilities for program planning in both public health and medical care and also to administer hospitals."

In this paper some of the problems which confront these young doctors on the Navajo Reservation are discussed. They are presented in the immediate context of the medical service in that region, but it is believed that many of these same problems and their solution have a broader generality to cross-cultural medical practice which has had such a rapid expansion in other areas of the world.

The physician starting on the Navajo Reservation faces a number of difficulties: learning to work effectively in a government organization; living and working in a relatively isolated social and medical community; comprehending the importance of cultural differences and the language barriers as they are related to the medical program; and recognizing that the pattern of disease and the nature of the clinical work on the Reservation call for a general medical and public health approach.

Problems Related to Government and Reservation Living

Most young doctors assigned to the Navajo Reservation have joined the United States Public Health Service to fulfill their draft obligation. All of these doctors have completed their internship; some have had a year or more residency in medicine; surgery, pediatrics or another specialty.

Physicians like many other citizens have little knowledge about how the government really operates. They may have no understanding about such matters as the important role of the Bureau of the Budget, the steps involved in obtaining necessary Congressional appropriations, the problem of categorized and "earmarked" funds, budget "freezes," and other vital information about government fiscal procedures. Lacking this knowledge the physician may not appreciate the problems which the local administrators encounter in attempting to provide an adequate medical program.

It may take a full year for the most adaptable doctors to adjust to government medical practice; to accept the administrative authority of his chief; to work without undue frustration within established "channels;" to accept the burden of "paper work" as an inherent part of a governmental activity. As a clinician the physician has long been accustomed to looking to his chief or superior as the final arbiter and counselor for his medical diagnoses and treatment. However, in the government health organization as in any large health program, the physician's chief or superior may well be an able administrator with only secondary interest in the practice of clinical medicine. Some of the more rigid doctors take on the attitude that "government" is a mass conspiracy solely invented to keep them from seeing their patients.

Additionally, there are numerous family problems which face the physician new to the Reservation—problems similar to those which face technical personnel in Point Four programs.

* John J. Adair, Ph.D., is Assistant Professor of Social Anthropology in Public Health and Preventive Medicine; Kurt Deuschle, M.D., is Assistant Professor of Public Health and Preventive Medicine, Cornell University Medical College, New York.

1. *Health Services for American Indians,* U.S. Department of Health, Education, and Welfare, Public Health Service, 1957, p. 115.

First, the geographic features of the arid Southwest are very different from most regions they have known in other parts of the United States; the living in small government communities isolated from public schools, shopping facilities, etc., are equally unpleasant to these doctors' families. The housing facilities may be inadequate especially for physicians with larger families. Additionally these families, along with those of government employees in other job capacities, form a minority community with only very limited social contacts with the Navajo among whom they live. This gives rise to all the problems of a small outpost society.

In some instances the social pressures of the government town may result in such a heavy on-and-off the job stress that it undermines the doctor's work and affects his total family adjustment to the Reservation life.

It is difficult for the doctor to get away from the worries and pressures of the job, living as he does right in the community where he works. Where several physicians are working together in places like Fort Defiance, shop talk goes on virtually around the clock and even the wives become involved in professional matters along with their husbands. There are none of the usual ways of dissipating the anxiety engendered by the job, as there is in the more normal community where one's work, family life, and social activities each have their own rather than the same orbit. When such stress is felt by any one of the doctors in this very closely knit society, it may spread to the whole community and rapid demoralization may set in. On the other hand, in remote clinics like the Chinle Health Center there is the problem of the physician working entirely alone without being able to discuss a perplexing medical case with a professional colleague.

Often the first compromise the physician must make in his new work in Reservation practice is with medical facilities. He may have been accustomed to the finest medical library, adequate laboratory and X-ray service, nursing help, and medical specialist consultants. In contrast to the well-equipped Fort Defiance and Tuba City Hospitals, laboratory and X-ray facilities may be lacking in the more isolated field clinics of the Navajo Reservation. Because of the shortage of technical and clerical assistance the professional staff must often perform many tasks which could be delegated to other trained personnel. This, of course, is not unique to the Navajo Reservation for shortages of equipment and medical personnel hound every medical administrator from Seattle to New York City. The challenge to the physician is to determine the irreducible minimum of needed facilities and personnel required to perform an adequate medical job rather than to regard these minimal facilities as evidence that good medical work is not expected.

Language and Cultural Problems

A source of considerable frustration to the physician is his inability to talk directly to his Navajo patients. The doctor is unable to judge the patient's subtleties of expression, the tone of voice and inflection, the turn of a phrase which is so important in communicating emotional tone in English. These cues do not come through when working with an interpreter—the whole affect is dulled in the process of interpretation. Moreover, the physician misses the gratification he gets from patients elsewhere when they are able to express their thoughts to the doctor directly. Here what rapport he obtains is again developed through the interpreter. Even a pediatrician treating infants in our society has the satisfaction of talking with the families of his patients. Because of the language barrier, the physician may fall into the habit of addressing himself to his interpreter rather than the patient. This the patients resent, and have been known to complain "these interpreters get between us and the doctors." The importance of the medical history, in fact, becomes secondary to the medical examination in most clinics simply because of the difficulty in getting adequate histories through these interpreters.

All the physician's technical knowledge in explaining the nature of the illness, the plan for treatment and follow-up recommendations must be funneled through the interpreter. The extent to which the physician can communicate with the patient depends on how effective the Navajo interpreter performs his job. Eventually the interpreter who is well-used (and has been well-trained) becomes, so to speak, the instrument of the physician.

The physician may fail to realize that the literal interpretation usually possible between European languages and English is quite impossible between languages so different structurally as English and Navajo. Even when Italian or Puerto Rican patients cannot speak a word of English they may break through the language barrier to some extent with their volatile and demonstrative expressions. In contrast the behavior of the stolid and undemonstrative Navajo patient serves to magnify the language barrier.

There are numerous other problems which center around the matter of medical interpreters. One of these problems is that of selecting the medical interpreter. Thus far no standard has been set nor systematic screening method devised for the selection of medical interpreters. Usually doctors are attracted to interpreters with whom they have the best rapport, who speak the best English, have the nicest "appearance" yet whose ability in speaking their own language—which may have suffered from years away from the Reservation while in government boarding schools—remains untested.

The consequence of this lack of training for interpreters in the concepts of medicine and lack of experience of the young doctor in how to select, train, and use an interpreter results in a situation which remains highly unpredictable in any given hospital, outpatient clinic, or field health installation.

The failure to select a medical interpreter properly can sometimes result in ridiculous errors as the following incident which occurred at the Fort Defiance Indian Hospital several years ago illustrates:

> A doctor hard pressed for an interpreter asked a Navajo kitchen helper to interpret for him one day. She spoke as good English as the regular interpreter and the doctor had no reason to doubt her competence in her own language. The girl was ashamed to confess her ignorance and proceeded to interpret as requested. She told the patient that she would have to have her appendix removed while in reality the doctor had ordered a routine radiograph of the chest.

It should be noted, however, that even in our own urbar clinics where there is no language barrier the level of communication between the physician and the patient and of th·

patient's understanding of his own disease as revealed by the doctor is far from satisfactory. The situation in doctor-patient relations on the Navajo Reservation is not so different in kind, but is intensified in several particulars. Among these are: 1) lack of education of the patients in our medicine, 2) the presence of the language barrier which requires funneling all information through an interpreter, and 3) lack of knowledge on the physician's part of those aspects of Navajo culture which have a direct relation to the curing process.

The physician who is unsophisticated in Navajo ways may get into difficulty in evaluating certain situations that occur in the clinic or hospital. For example, the Navajos are so-called "good patients" because they accept and endure certain painful procedures stoically; this may mislead some unwary physician into thinking that the Navajos do not experience pain as sharply as his Anglo patient. Occasionally a physician will continue a difficult venipuncture or other minor surgical procedure because of the patient's seemingly high threshold to pain.

A notable illustration of this point had to do with an obstetrician who administered a minimum of analgesics for his Navajo patients in labor on the assumption that the Navajos had very little pain since they "probably experienced a more natural reaction to childbirth." After this obstetrician completed his tour of duty the physician who succeeded him administered much larger doses of analgesics. Very soon thereafter, the obstetrical patient load at this Navajo hospital increased sharply. When some of these Navajo women were queried as to why they were coming into the hospital they replied: "To have a baby without pain!"

There are numerous other pitfalls for the physician inexperienced in the area. He may ask the ward orderly to take care of a corpse, and get an outright refusal; or if the order is carried out the orderly may request the following day off so that the correct ritual may be performed to cleanse the body of the evil that comes from close associations with the dead.

The doctor may be baffled by the refusal of a patient's relatives to donate blood for indicated surgery or the treatment of anemia. He may not realize that the concepts of sympathetic and contagious magic are still strongly believed in by most of the Navajos. In this instance, if the patient were to die, then the donor of the blood might also sicken and die.

Numerous other points of resistance could be mentioned: the reluctance to take rectal temperatures (probably related to witchcraft usage of feces); the dislike of appearing naked before the doctor (sanctions of modesty are highly developed among the Navajo); the constant series of requests for "time off" on the part of Navajo employees (in order to have the correct counteractive rituals) and requests for medical leave from the sanatoria by a patient who wants to go home for a "sing" which is Navajo healing ceremony.

These points of resistance serve to alert the doctor to the fact that the Navajo patient is certainly very different "from the patient back home." He also comes to realize as a result of his own experience that Indian employees demand in their relationship to the doctor tremendous patience, and the nurturing of a close and sympathetic attitude. The impersonal rigid relations which are traditional to hospitals and clinic management in our own society tend to increase the gap between the doctor and the nurse in their world, and the Navajo patient and employees in theirs.

It is equally easy for the physician to err on the side of being over-indulgent in acquiescing to Navajo custom and tradition. This is illustrated by an incident which occurred at the Fort Defiance Hospital several years ago. The surgeon who was treating a patient with severe burns granted the family permission to visit the patient with the medicine man. A curing rite was performed while the patient was unattended by the hospital staff. The herbal infusion which was spat on the patient's wounds during the ceremony resulted in a fatal infection. This incident demonstrates the importance of being highly selective in granting concessions to Navajo tradition when the patient's health status may be compromised. Had the "sing" been performed without the application of the herbal infusion the psychological benefit of the ritual could have been achieved without the danger of infection.

The pity is that each physician must learn most of this for himself. To be certain, those on the job before him may well brief the new doctor in a casual way about the "do's" and "don'ts" of working with Navajo patients; nevertheless, a handbook with relevant cultural materials is needed by the clinician. Many of these data can be found in a few books and monographs, for the Navajo Indians have been the subject of intensive study and research by anthropologists. It is ironical that so often physicians learn by trial and error the complex matters of the cultural differences when there is such a rich literature available. This raises a host of problems not germain to the central theme of this paper, problems concerned with communication between anthropologists and government administrators and anthropologists and the professions. Suffice it to say that this lack of communication is as much, if not more, a failure of the anthropologist as it is of the doctor or public health officer.

The physician who has longer-term bed patients in the hospital or who does service in a tuberculosis sanatorium is in a good position to see the broader context of Navajo disease and health. There, as in sanatoria in our own society, he has an opportunity to get to know his patients and their families who make frequent visits. He gains an understanding of the important part the family plays in the care of the ill in Navajo society. Within recent years there has grown up in the sanatoria a willingness on the part of the doctors to permit their patients leave so they may have their own "sings" at home. This too has a broadening effect on the doctor's thinking and Navajo traditional medicine becomes relevant to problems of medical care. Furthermore, the physician who deals with tuberculosis has the problem of educating the patient to his illness. If he is perceptive, he soon learns that the germ theory as such has no meaning for the Navajo. They tend to keep their own native theory of disease and are not won over by scientific demonstrations such as looking at microbes under the microscope.[2] While the physician learns that our scientific explanations of the cause of disease fall on deaf ears, he also learns that the

2. It has been the experience of anthropologists working in other world areas that changing native concepts of disease etiology is most difficult, and not essential to public health programming. William Caudell, "Anthropology and Public Health," in A. L. Kroeber, *Anthropology Today*, Chicago, University of Chicago Press, 1953.

Navajo patient takes considerable interest in the progress of his treatment. Radiographs are examined with great interest not only by the patient, but by his whole family.

The physician may recognize the importance of cultural differences when the violation of custom and ensuing resistance on the part of the Navajo are perceived. However, this is just the beginning of cultural awareness. Too often the subtleties of cultural differences are missed altogther or are learned after a harsh experience. For example, the harried physician may be chagrined to discover that the hours of precious time he spent convincing the husband of one of his patients to continue hospital treatment had been completely wasted. The family member who really wielded the power of decision in this matter—the patient's grandmother—had been directed to the waiting room to sit while the parley had taken place. That such events should occur is quite understandable, for the wards and clinics are usually full and the pressing problems of diagnoses and treatment do not allow the physician a great deal of time to investigate such matters. From the moment the physician arrives on the job he is under such heavy work pressure that there is little time to schedule group conferences and workshops for such matters as language and cultural problems.

The Public Health Point of View

Tremendous progress has been made in some 76 different medical schools scattered throughout the United States in graduating consistently well-qualified physicians who meet the medical needs and demands of American 20th century society. These graduates of our medical colleges are well-trained in the basic scientific principles of medicine and in the clinical practice of medicine in its advanced technology.

In the crowded medical curriculum students are given basic principles of public health but very little time can be spared for topics dealing with a relatively primitive situation. It is obviously impossible for the medical schools to train the students for every conceivable situation which they may face after graduation.

The common public health problems which were personal experience to medical students of fifty years ago when they could relate the typhoid fever patient in the hospital ward to obvious community sanitary practices have become the concern of the state and municipal health departments. Much of the training in public health has been postponed for the physician interested in establishing a career in this field until he can enroll in one of the postgraduate schools in public health.

In many medical schools where the public health courses are given in the undergraduate curriculum, the students build up a passive indifference to the problems presented in the classroom. The immediate need for knowledge in the field is not nearly as pressing as biochemistry, bacteriology, pathology, and subjects directly pertinent to training in clinical medicine. In fact many students build up a negative attitude towards public health — and these may be the same students who find themselves working for the United States Public Health Service, under the "doctor-draft" within a period of a few years.

Furthermore, on the Navajo Reservation the medical problems are not rare illnesses but rather common diseases which are frequently seen in an advanced state because of neglect or delays inherent in getting the patient to a hospital facility.[3] As in other areas where infectious diseases are the major medical problem, the nature of the service demands immediate attention to acute illness; month in and month out medical practice on the Navajo Reservation resembles in some ways the crisis situation in treating the victims of an epidemic.

The very nature of the medical service and the pattern of disease among the Navajos demand that the physician concentrate on the health problems at hand rather than only those he would consider in his field of special medical competence. This may not be as simple as it first would appear. There has been an increasing trend *at the postgraduate* training level in our university hospitals to train medical specialists. Some of these specialty groups have become so highly organized and "unionized" that the practicing members must confine themselves rigidly to practice within certain age groups, disease categories, or special organs or organ systems. Therefore, it is not surprising to find that some physicians reluctantly undertake medical care outside their area of special training. However, the effective physician on the Navajo Reservation is quick to "wash out" the specialty lines and tackle the pressing medical problems to the best of his ability.

Some of these young physicians look beyond the immediate problems in the examining room and seek answers to the cause of disease in the larger environment beyond the hospital walls. In most cases these are also physicians who have learned to work effectively as members of the government medical team, and while they might never approve of cumbersome procedures, they have mellowed in their attitude and have learned that there are effective ways of working within channels.

Some may go on to a career in public health and of these some will seek further training in a graduate school of public health. These physicians share a point of view more akin to that of the public health physician from such areas as India and Southeast Asia. There is a functional reason why this convergence in point of view has taken place—two years before (when the U.S. physician just finished his internship), their thinking was miles apart. In areas of underdeveloped economy, where there is mass illiteracy and a high rate of child mortality and infectious disease, the physician, if he is going to be effective, has no alternative; he must come to grips with preventive medicine and public health programs. He has come to realize that social, behavioral, and economic factors are as important a part of the environment of disease as the human host itself.

All the physicians on the Navajo Reservation are not "two-year men" fulfilling draft obligations. The directors of the service are public health career doctors and nurses, many of whom have been transferred from other branches of the U.S. Public Health Service, such as the Bureau of State Services. Some were with the Bureau of Indian Affairs before the U.S. Public Health Service took over.

The job of the public health administrator on the Navajo Reservation is difficult indeed. One example of a dilemma

3. John Adair, Kurt Deuschle and Walsh McDermott, "Patterns of Health and Disease Among the Navajos," The *Annals* of the American Academy of Political and Social Science, 311, 80 (1957).

with which the public health officer must struggle will serve to illustrate the point. The Navajos do not have the same concept of time as we have in our society. Thus a sick Navajo living in the bottom of a canyon may decide to saddle his horse and ride to the nearest field clinic to obtain some medicine late Friday afternoon. When he finally arrives at the clinic on Friday night he finds the clinic doors locked and the doctor away for the weekend. The Navajo patient cannot understand why he does not get medical service after his arduous trip to the clinic. The problem which the public health administrator must resolve is how to keep the professional staff on a reasonable work schedule and yet be able to provide adequate medical care to Navajos who live in a vastly different cultural framework.

Thus, the degree to which the public health administrator is successful in carrying out a health program depends on his ability to evaluate these cultural differences and adapt his program accordingly. He must take cognizance of the lack of community organization as we know it and of the extended family system tied closely to the clan organization. These present a series of cultural differences to the public health administrator which are more like those encountered in the rural areas overseas than in other parts of the United States.

In marked contrast to such community differences, the Navajos have developed a strong central tribal governing body. This group—the Navajo Tribal Council—includes 74 elected representatives. They have always shown a remarkable interest and concern in health matters. The public health administrators have obtained ready cooperation and advice for their medical programs from the Tribal Council through their Health Committee. It can be said that the public health administrator probably is able to get much more support and action from the Tribal group than he could expect from a similar municipal or county governmental organization in our own society.

In addition to these problems in public administration, the career officer is ultimately responsible for the smooth functioning of clinics and hospitals with all of the problems of interrelationships between Navajo patients and newly inducted doctors, fresh from medical college, which are briefly described above.

Conclusion

The problems which the physician encounters on the Navajo Reservation are not unlike many challenges in life which we all meet. In effect, the solution depends on the ability of the physician to adapt and adjust his knowledge and skill learned in one situation and to apply the same principles in meeting a markedly different set of circumstances. The imaginative physician will do this instinctively whereas the more rigid physician will probably fail to adapt regardless of how much is done for him. However, the average doctor could probably derive considerably more satisfaction from his work in areas of low technology and different cultural patterns if he received special education, training, and orientation for this work.